Overseas Screening Requirements

Active duty members are responsible for ensuring that they have met the following requirements before coming in to their appointments.

Requirements for active duty members:

1. Current PHA or flight physical. (within the last 12 months)
2. Dental class one or two. (classes three and four are non-deployable)
3. No outstanding medical issues. i.e.(surgical procedures, mental health treatment, physical therapy)
4. No outstanding dental issues. i.e.(major dental procedures)
5. For females Pap smear needs to be current within one year, with normal results. Females age 40+ a mammogram is required within the last 24 months.
6. A completed DD2807-1.
7. A NAVMED 1300/1.
8. A NAVPERS 1300/16.

Requirements for dependants:

1. For females (18 years and older) a Pap smear needs to be current within two years of transferring date and results need to be normal. Females 40 years and older require a current mammogram.
2. Immunizations required by the host country must be up to date. Immunizations clinic phone number is (360) 257- 9591.
3. No outstanding medical issues. i.e.(surgical procedures, mental health treatment, physical therapy)
4. No outstanding dental issues. i.e.(major dental procedures)
5. Dental clearance on (NAVMED 1300/1 page 3) needs to be completed by their dentist.
6. Children must have a current well child exam (within 12 months).
7. A completed DD2807-1.
8. A NAVMED 1300/1.

If you have any questions or difficulties completing any of the listed requirements please do not hesitate to contact the NHOH Suitability office. If you are unable to complete these requirements before your appointment you may reschedule through TRICARE 1-800-404-4506 or contact the NHOH Suitability office.

Phone (360) 257 – 9830.

Email:ssc-nh-oakharbor@med.navy.mil

Website: http://www.med.navy.mil/sites/nhoh/Services/Pages/SSC.aspx

IMMUNIZATIONS

Japan:

MMR

DPT

Poliovirus

Hepatitis B

Japanese encephalitis

Guam:

MMR

DPT

Poliovirus

Hepatitis A & B

Typhoid

Italy:

MMR

DPT

Poliovirus

Hepatitis B

If your host country is not listed here please refer to the CDC's guidelines.

CDC website: http://wwwnc.cdc.gov/travel/destinations/list.aspx

Instructions for Completing Forms

Complete these forms prior to your appointment.

DD2807-1:

1. Complete blocks 1 – 9. Please write legibly.
2. For blocks 10 – 28 answer the medical questions as they apply to you. If you have any "YES" answers a brief explanation is required in box 29 on page 2.
3. Ensure that your name and full SSN is filled in at the top of each page.

NAVMED 1300/1:

1. Fill in your personal information at the top of page one and three.
2. Do not answer any of the medical questions on this form. They are to be completed by medical and dental personnel.
3. Page three is to be completed by a civilian or DOD dentist. The dentist should refer to box 8 for descriptions of the four dental classifications.

Memorandum:

1. This form is for the sponsor only.
2. Fill in your name, rank, and your present command.

NAVPERS 1300/16:

1. This form is for the sponsor only.
2. Fill in your personal information at the top of each page.
3. Answer questions 1-16 on pages one and two. Note(For personnel E-4 and below you must be counseled on questions 1-16 by a senior member in your chain of command)
4. If you have accompanied orders list your dependants on page three in boxes 2-6.
5. Page four will be filled out by your admin department **after** your medical screening has been completed.

If you have any questions or concerns, please refer to our website or contact the NHOH suitability office.

Website: http://www.med.navy.mil/sites/nhoh/Services/Pages/SSC.aspx

Phone: (360) 257 9830

Email: ssc-nh-oakharbor@med.navy.mil

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413
OMB approval expires Mar 31, 2010

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confine- ment or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
b. HOME TELEPHONE *(Include Area Code)*	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		7.a. POSITION *(Title, Grade, Component)*
☐ Army ☐ Coast Guard	☐ Active Duty	☐ Enlistment	☐ Medical Board ☒ Other *(Specify)*	
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement sea screen.	b. USUAL OCCUPATION
☐ Marine Corps	☐ National Guard	☐ Retention	☐ U.S. Service Academy	
☐ Air Force		☐ Separation	☐ ROTC Scholarship Program	

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

Privacy Act Statement
Authority: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).
Purpose: To identify medical, dental or educational conditions for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.
Routine uses: This form is completed by a military/civilian physician, nurse practioner, physician assistant, or independent duty corpsman. The medical treatment facility (MTF) Suitability Screening Coordinator will place the completed original form in the service or family member's MTF medical record and retain a copy for audit.
Disclosure: Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2A for implementing guidance. ***Complete one form for each service and family member screened.***

SERVICE MEMBER NAME	GRADE / RATE	SSN
FAMILY MEMBER NAME	**FAMILY MEMBER PREFIX**	**SSN**

NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC):	TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)

PART I

Medical Screening. Completed by the medical provider to identify special needs and determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. Attach the completed Report of Medical History (DD 2807-1) to this form.

Yes	No	N/A	ITEM
			1. All current health records (military and civilian) reviewed?
			2. Physical examinations (aviation, submarine, radiation, asbestos, etc.) current and documented?
			3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
			4. Immunizations are up-to-date and meet destination country requirements?
			5. Reference audiogram documented on DD 2215?
			6. Latest audiogram (DD 2216) reviewed?
			7. HIV testing completed or drawn?
			8. DNA testing completed and documented?
			9. Are there pending consults or tests that have a bearing on assignment suitability?
			10. Any past limited duty or medical board(s)? *(document on DD 2807-1)*
			11. For all service members, annual preventive health assessment (PHA) current and documented?
			12. For servicewomen:
			a. Annual health assessment current and documented?
			b. Pregnancy screening (verbal inquiry)?
			c. If pregnant? (EDC:)
			13. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
			14. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			15. Are there any conditions requiring ongoing care in the following areas? *(document on DD 2807-1)*
			a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
			b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
			c. Gynecologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
			d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
			e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
			f. Mental health or behavioral conditions (e.g., mood, adjustment/personality disorder, ADD/ADHD, anxiety, psychosis)
			g. Recurrent or frequent medications not on the standard formulary *(list on DD 2807-1)*
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			16. For service/family members requiring medication in excess of 90 days: (if not applicable, check block and skip to #18)
			a. Is the patient in the maintenance phase of treatment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Is the medical staff at the gaining MTF/operational platform capable of managing the medication manipulation(s) if the underlying condition exacerbates?
			d. Has the service/family member registered with the TRICARE Mail Order Pharmacy program?

Yes	No	N/A	ITEM
			17. For service/family members with underlying medical conditions: *(if not applicable, check block and skip to #18)*
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Can the gaining MTF/operational platform provide the current required medical support?
			d. Can the gaining MTF/operational platform provide required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated?
			e. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? *(document on DD 2807-1)*
			f. If required, were potential environmental concerns and possible health effects communicated to each service and family member? *(document on appropriate SF 600)*
			18. For infants and toddlers (birth through 2 years, inclusive) with a disability, is the child receiving or eligible to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			19. For preschool and school children (ages 3 through 21, inclusive) with a disability, is the child receiving or eligible to receive special education and related services as evidenced by an Individualized Education Program (IEP) and DD 2792, Addendum B?
			20. Specify other concerns:

IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, QUERY THE GAINING MEDICAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY OR OPERATIONAL LOCATION CONCERNING LOCAL CAPABILITIES TO PROVIDE REQUIRED SUPPORT. *(Attach Reply)*

Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(completed by an MTF medical screener only)*

MTF Medical Screener (Signature) Date	Civilian Medical Screener (Signature) Date
Printed Name, Rank or Grade	Printed Name
MTF or Duty Station	Address
Telephone Number (include area/country code)	City, State, and ZIP Code
DSN Number	Telephone Number (include area/country code)
Telefax Number (include area/country code)	Telefax Number (include area/country code)
E-mail Address	E-mail Address

PART II

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN

Dental Screening. Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility.

Yes	No	N/A	ITEM
			1. All current dental records (military and civilian) reviewed?
			2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
			3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
			4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
			5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
			6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
			7. Specify other concerns:

8. Specify Dental Class: *(required for service members)* _____

Dental Classifications: (Per DoDI 6025.19)

Normally considered worldwide deployable:
Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation.
Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.

Normally not considered worldwide deployable:
Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.
Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

IF ANY OF THE ABOVE SHADED BLOCKS ARE CHECKED, FORWARD A SUITABILITY INQUIRY TO THE GAINING MEDICAL TREATMENT FACILITY OR MEDICAL DEPARTMENT SUPPORTING THE OVERSEAS, REMOTE DUTY, OR OPERATIONAL LOCATION TO DETERMINE IF THE REQUIRED DENTAL SUPPORT IS AVAILABLE. *(attach reply)*

Yes	No	IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(completed by an MTF designated military dental screener only)*

MTF Medical Screener (Signature) _____ Date _____	Civilian Medical Screener (Signature) _____ Date _____
Printed Name, Rank or Grade	Printed Name
DTF or Duty Station	Address
Telephone Number (include area/country code)	City, State, and ZIP Code
DSN Number	Telephone Number (include area/country code)
Telefax Number (include area/country code)	Telefax Number (include area/country code)
E-mail Address	E-mail Address

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
3475 N SARATOGA STREET
OAK HARBOR, WASHINGTON 98278-8800

From: Transfers Section, Personnel Support Activity Detachment, Whidbey Island WA.

Subj: SCREENING FOR ASSIGMENT TO SEA DUTY.

Ref: (a) NAVPERS 15909E Chapter 24

(b) BUMED Washington DC 210129z DEC94

(c) MANMED Art 15-30

1. Per reference (a) through (c), medical and dental screenings are required to be completed and documented prior to transfer to sea duty.

Rank/Rate Name : _____

Present Command: _____

FIRST ENDORSEMENT

From: Commanding Officer, Naval Hospital Oak Harbor

To: Transfers Section, Personnel Support Activity Detachment Whidbey Island.

1. Per references (a) through (c) member has been screened and is considered to be **MEDICALLY** suitable/unsuitable and **DENTAL** suitable/unsuitable for duty with _____
(UNIT/COMMAND/SQUADRON)

_____ _____

Signature of MEDICAL DOCTOR/IDC Signature of DENTIST

DATE_____ DATE_____

REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENTS

Supporting Directive OPNAVINST 1300.14D

1. MEMBER'S NAME:		2. DATE:	3. NUMBER OF DEPENDENTS:
4. PRESENT SHIP/STATION:	5. UIC:	6. OVERSEAS LOCATION:	7: UIC:

PART I: COMMAND REVIEW - The purpose of the command review is to determine, via record review and personal interview, member and spouse/family member(s)' suitability for overseas duty/life in the assigned overseas location. Refer to MILPERSMAN 1300-302 and 1300-304. Any questions checked "YES" (with the exception of questions 11, 15, and 16) disqualifies member for overseas assignment. Complete PART I and obtain waiver(s) prior to starting PART II (NAVMED 1300/1).

1. Has the member or any spouse/family member previously been reassigned, prior to normal tour completion, due to their unsuitability?	◯ Yes	◯ No
2. (For Enlisted Personnel) Has member obligated for the prescribed DoD tour? If "NO", member is unsuitable. NAVPERS 1070/613 entries for OBLISERV are prohibited. OBLISERV MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS. For SRB issues, see the current NAVADMIN. For PFA see current NAVADMIN and OPNAV instruction. Officers and enlisted who REQUEST to separate/retire, will be held to the DoD tour length.	◯ Yes	◯ No
3. (E-5 and above) Does the member, spouse, or family member have serious problems of indebtedness, credit loss, or other financial problems which have not been reconciled with the creditor(s) or interested parties?	◯ Yes	◯ No
(E-4 and below) Member must complete debt-to-income (DTI) ratio screening per OPNAVINST 1740.5B. Do not calculate the spouse's income unless guaranteed employment at the overseas location has been obtained. Is the DTI ratio 30% or greater.	◯ Yes	◯ No
4. Has the member ever been convicted of a sex offense?** Has the member been convicted of any criminal offense (civilian or military) within the last 24 months or has/had any involvement in an ongoing criminal action? **Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov.	◯ Yes	◯ No
5. Has the spouse or any family member ever been convicted of a sex offense?** Has the spouse or any family member been convicted of any criminal offense (civilian or military) in the last 24 months or has/had any involvement in an ongoing criminal action? ** Information regarding whether a person is a sex offender may be found at Dru Sjodin National Sex Offender Public Website (NSOPW) at www.nsopw.gov.	◯ Yes	◯ No
6. Does the member have a record of any involvement with illegal drugs or alcohol within the past 24 months? Successful completion of an aftercare program will qualify the member and the question can be answered NO. Waiver of aftercare program does not quality the member; answer YES.	◯ Yes	◯ No
7. Does the spouse/family member have a record of any involvement with illegal drugs or alcohol within the past 24 months?	◯ Yes	◯ No
8. Is the member or spouse/family member involved in an open Family Advocacy Program (FAP) case that is still under investigation or for which treatment was refused or is still ongoing? (If a local FAP representative is not available to provide a status of any FAP issues, then contact the Commander Navy Installation Command (CNIC), Lead of Case Management Section for FAP, at (901) 874-4361, DSN 882-4361, for this endorsement.) If the CO still wishes to request a waiver, then the gaining command and FFSC must support waiver request.	◯ Yes	◯ No
9. Was the member's spouse previously a member of the Armed Forces and the characterization of separation other than "Honorable"? Explain in the remarks section.	◯ Yes	◯ No
10. Has member failed two or more PFAs in a 3-year period? If yes, comply with OPNAVINST 6110.1H and most recent NAVADMIN, which govern Physical Readiness Program.	◯ Yes	◯ No
11. Are any of the member's dependents covered in a custody agreement? If "NO", go to question 12.	◯ Yes	◯ No
a. Does agreement prevent removal of family members from continental United States (CONUS) without prior court approval or agreement between the interested parties? If "NO", go to question 12.	◯ Yes	◯ No
b. Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law? (Please note: Navy policy does not require a separate agreement if not required by state law.)	◯ Yes	◯ No

1. MEMBER'S NAME:	2. DATE:

12. Single parents/military couples with family members. Is there any reason why the Family Care Plan cannot be executed or is not in accordance with OPNAVINST 1740.4D?	◯ Yes	◯ No

NOTE: While the unique situation of single parents with dependents is not disqualifying, this fact should be pointed out upon submission of suitability determination.

13. If member is a first-termer and going to an overseas duty station, and has a pre-service moral waiver(s) for drug, alcohol, or criminal conviction, (identified in Section VI remarks of DD 1966 (3-07), Record of Military Processing), then mark block YES.	◯ Yes	◯ No
14. Does member have a history of unsatisfactory or below standard performance (any mark below 3.0) or any NJPs in the last 2 years?	◯ Yes	◯ No
15. Have member and adult dependents received "Level I" Antiterrorism Force Protection (Level III for 0-5/0-6 Commanding Officer Awareness Training), prior to transfer, and recorded on NAVPERS 1070/613?	◯ Yes	◯ No
16. Is dependent spouse a foreign national? If yes, see MILPERSMAN 1300-302 for "Non-US citizen dependents". Case by case coordination for dependents travel documents will be required.	◯ Yes	◯ No

FOR PERSONNEL E-3 AND BELOW: Ensure the members have been counseled that they cannot be assigned accompanied overseas duty. Members will be assigned unaccompanied based on readiness needs. Acquiring family member(s) en route and bringing them without dependent entry approval/command sponsorship will most probably result in return to CONUS at personal expense and servicemembers will complete tour unaccompanied.

1. I have been counseled on the above: ◯ Yes ◯ No

2. MEMBER'S SIGNATURE:	3. DATE:

4. REMARKS:

5. I, _____ , am aware that the failure to divulge disqualifying information or amplifying information (medical, dental, personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.

6. MEMBER (NAME, RANK/RATE):	6. MEMBER (SIGNATURE)	7. DATE:

8. INTERVIEWER (NAME, RANK/RATE, COMMAND TITLE):	9. INTERVIEWER (SIGNATURE)::	10. DATE:

1. MEMBER'S NAME:	2. DATE:

PART II: RECOMMENDATION OF COMMANDING OFFICER (OR OIC) OF MEDICAL TREATMENT FACILITY.

Based on the information available as a result of screening, approved medical/dental waivers received, and on the capabilities of the Medical/Dental Treatment Facility (MTF/DTF) in the area of assignment to which ordered, the following recommendation is forwarded.

1. Medical, dental, and educational screening was conducted per BUMEDINST 1300.2A.

2. Recommendation is based on a review of NAVMED 1300/1, Parts I and II. One form has been completed for each service and family member screened.

3. If a shaded block is checked on NAVMED 1300/1, coordination is required with the gaining MTF/DTF supporting the overseas, remote duty, or operational location; or with the senior medical department representative of an operational platform. Coordination must indicate whether or not required medical, dental, or educational capabilities are available.

4. Family member screening is not required if an unaccompanied tour of 24 months or less (exception: screening is required for Diego Garcia/ Souda Bay, Crete).

5. Do not forward sensitive medical or personal information with this form.

The following recommendation(s) are made based on a review of each NAVMED 1300/1, Parts I and II, and if required, the response from the gaining MTF/DTF or senior medical department representative of the gaining command:

1. SERVICEMEMBER IS SUITABLE FOR THIS ASSIGNMENT. ◯ Yes ◯ No

FAMILY MEMBERS SUITABILITY FOR THIS ASSIGNMENT.

2. NAME: ◯ Yes ◯ No	3. NAME: ◯ Yes ◯ No
4. NAME: ◯ Yes ◯ No	5. NAME: ◯ Yes ◯ No
6. NAME: ◯ Yes ◯ No	6. NAME: ◯ Yes ◯ No

The following family member(s) were referred for Exceptional Family Member Program (EFMP) enrollment (DO NOT DELAY SCREENING FOR EFM DETERMINATION):

8. NAME (s):

9. NAME OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:	10. DATE:	9. SIGNATURE OF CO/OIC OR DESIGNEE OF MEDICAL TREATMENT FACILITY:

1. MEMBER'S NAME:	2. DATE:

PART III: CMC/COB/SEA ENDORSEMENT

1. On the basis of all available information, I endorse ☐ / I do not endorse ☐ the member's orders for the overseas assignment.

2. CMC/COB/SEA (NAME AND RANK):	3. SIGNATURE OF CMC/COB/SEA:	4. DATE:

PART IV: COMMANDING OFFICER'S ENDORSEMENT

1. On the basis of all available information, I endorse ☐ / I do not endorse ☐ the member's orders for the overseas assignment.

2. COMMANDING OFFICER (NAME AND RANK):	3. SIGNATURE OF COMMANDING OFFICER:	4. DATE:

5. REMARKS:

If the Commanding Officer still feels member should be considered for overseas assignment, submit waiver (non-medical/dental) request per MILPERSMAN 1300-304.

PRIVACY STATEMENT: THE AUTHORITY TO REQUEST THIS INFORMATION IS CONTAINED IN 5 USC 301 DEPARTMENTAL REGULATIONS. THE INFORMATION WILL BE USED TO ASSIST OFFICIALS AND EMPLOYEES OF THE DEPARTMENT OF THE NAVY IN DETERMINING YOUR FUTURE DUTY ASSIGNMENT.

COMPLETION OF THE FORM IS MANDATORY EXCEPT FOR DUTY AND HOME PHONE NUMBERS, OR FAILURE TO PROVIDE REQUIRED INFORMATION MY RESULT IN DELAY IN RESPONSE TO OR DISAPPROVAL OF YOUR REQUEST.